

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

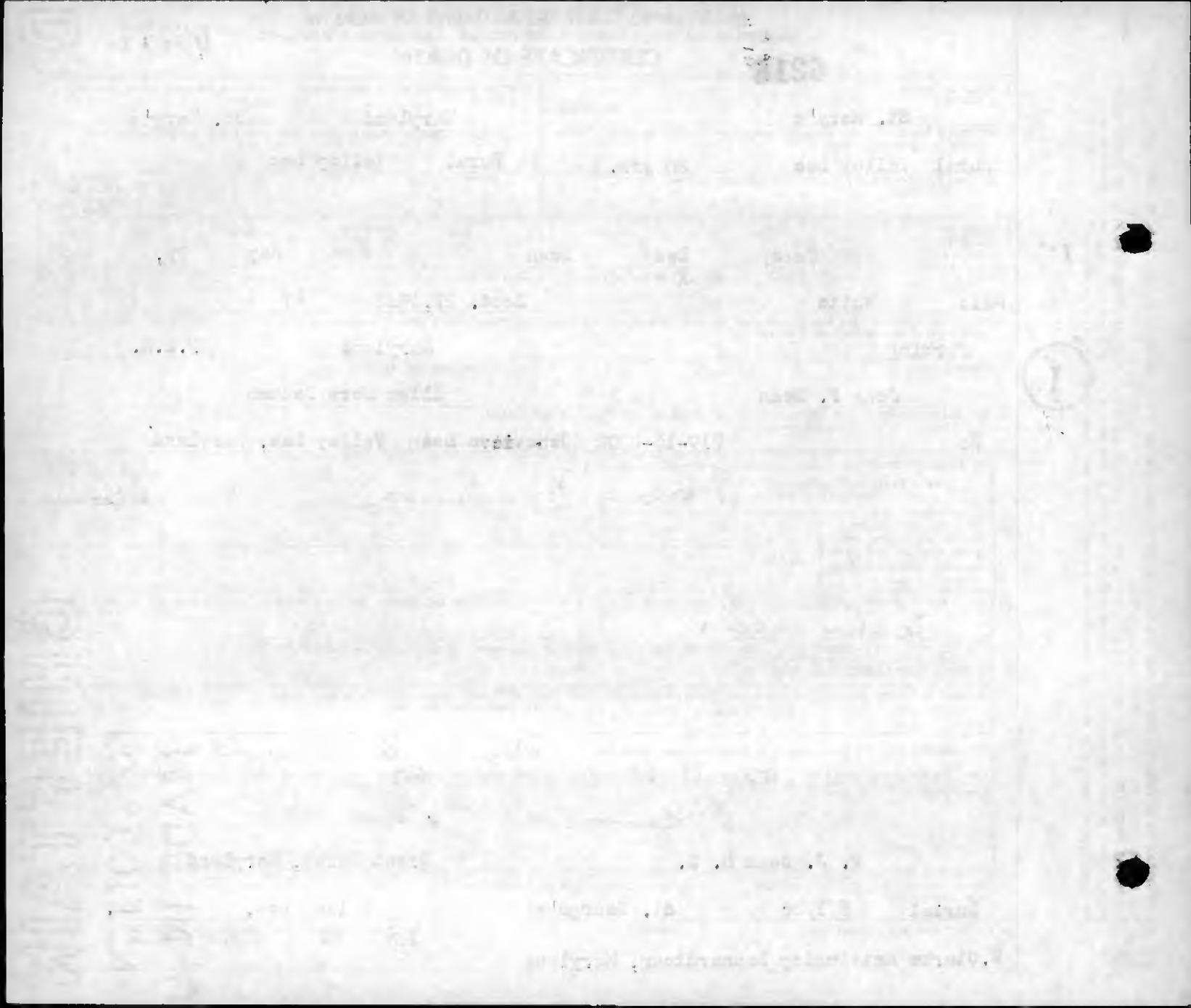
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06171

| | | | | | | | | | | | |
|---|--|--|--------|---|--------------------------|---|-----|--|--|--|--|
| 6216 | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Valley Lee | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Valley Lee d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS / | | | | | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Joseph Leo Bean | | First | Middle | Last | 4. DATE OF DEATH May 29, | Month | Day | Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 27, 1912 | | 9. AGE (In years last birthday) 47 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME John F. Bean | | 14. MOTHER'S MAIDEN NAME Ellen Dora Redman | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 219-16-2202 | | 17. INFORMANT Genevieve Bean | | Address Valley Lee, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | COPINGY DODGSION | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 hours | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO | | | | | | | | | |
| 420-1 | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | | | | | | | | |
| (c) | | DUE TO | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | Gastric ulcer | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 27, 1960, to May 29, 1960, that (I) (we) last saw the deceased alive on May 29, 1960, and that death occurred at 6 A.M. from the causes and on the date stated above. | | | | | | | | 22b. DATE SIGNED | | | |
| 22a. SIGNATURE P. J. Bean | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) P. J. Bean M. D. | | 22d. ADDRESS Great Mills, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 6/1/60 | | 23c. NAME OF CEMETERY OR CREMATORIUM St. George's | | 23d. LOCATION (City, town, or county) Valley Lee, Md. | | (State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley | | ADDRESS Leonardtown, Maryland | | 25a. REG'D BY REGISTRAR JUN 2 1960 | | 25b. REGISTRAR'S SIGNATURE <i>Curry S. Frame</i> | | DATE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

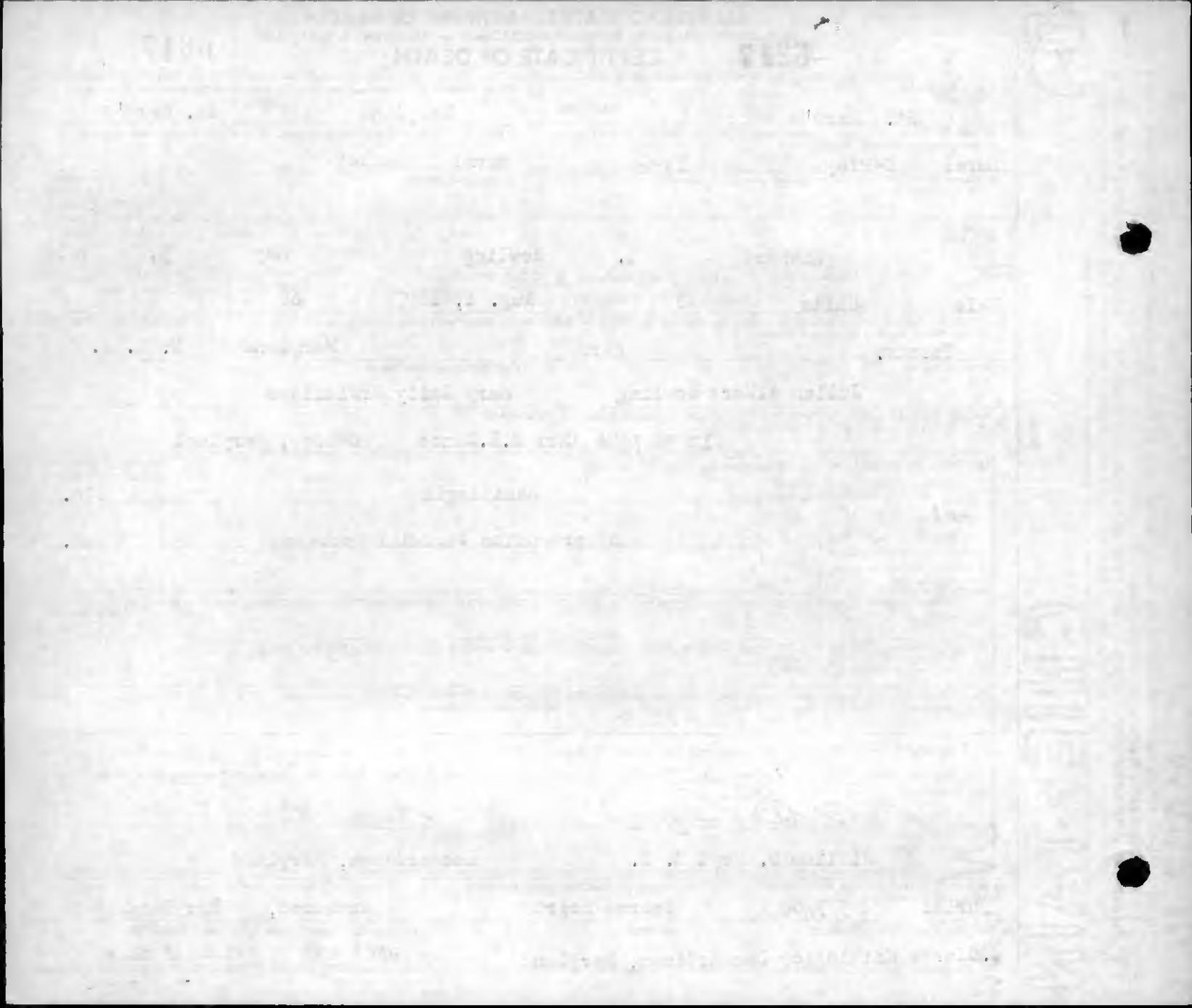
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6217

CERTIFICATE OF DEATH

06172

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakley | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Oakley | |
| | | f. STREET ADDRESS | |
| g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Richard | | First Q. | Middle Bowling |
| 4. DATE OF DEATH May 5, 1960 | | Month May | Day 5 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH Aug. 1, 1897 | | 9. AGE (In years last birthday) 62 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Julian Albert Bowling | | 14. MOTHER'S MAIDEN NAME Mary Emily McWilliams | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 217 36 7084 | |
| 17. INFORMANT Mrs M.E.Danos | | Address Oakley, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 447X | | 15 min. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | Hypertension Vascular Disease | |
| DUE TO | | 5 yrs. | |
| DUE TO | | | |
| DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 1949 to May 5, 1960 , that (I) (we) last saw the deceased alive on May 3, 1960 , and that death occurred at 3 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE MD Boyd | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) William D. Boyd M. D. | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22d. ADDRESS Leonardtown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5/7/60 | |
| 23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart | | 23d. LOCATION (City, town, or county) (State) Bushwood, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | ADDRESS | |
| | | 25a. REC'D BY REGISTRAR DATE MAY 10 '60 | |
| | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



FOR STATE
HEALTH DEPT.

TO DELIVER MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06173

| | | | | | | | | | | | | | |
|---|----------------------------------|--|---|--|---------------------------------------|---|--------------------------------------|---|--|---|--|---------|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | | b. COUNTY St. Mary's | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morganza | | c. LENGTH OF STAY IN 1b 1 week | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morganza | | d. STREET ADDRESS 1 Morganza | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | First John | Middle Alexander | Last Burroughs | 4. DATE OF DEATH Month May | Day 6 | Year 1960 | | | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH May 25, 1904 | 9. AGE (In years last birthday) 55 yrs. | IF UNDER 1 YEAR Months 5 | IF UNDER 24 HRS. Hours 5 | IF UNDER 24 HRS. Days 0 | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Alexander Burroughs | | 14. MOTHER'S MAIDEN NAME Susie Harrietta Stewart | | Address | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Sadie Burroughs | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) GUN SHOT PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) Shot self with shot gun - in neck | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. 11/14 5-6 1960 | | 20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME | | 20f. (City or town) MORGANZA ST | | (County) MD | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> W.D. Boyd | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> William D. Boyd | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> W. Clarke Mattingley | | DATE SIGNED 5/9/60 | | | | | |
| ACTUAL SIGNATURE W. Clarke Mattingley | | EXAMINER'S NAME (Type) William D. Boyd | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/9/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph | | 22d. LOCATION (City, town, or country) Morganza, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland | | ADDRESS | | 24a. REC'D BY REGISTRAR Office of Health | | 24b. REGISTRAR'S SIGNATURE Office of Health | | DATE MAY 16 '60 | | | | | |
| VS. AT SME SM 7/59 | | | | | | | | | | | | | |

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FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASH. D. C.

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FOR STATE
HEALTH DEPT.



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**80481**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

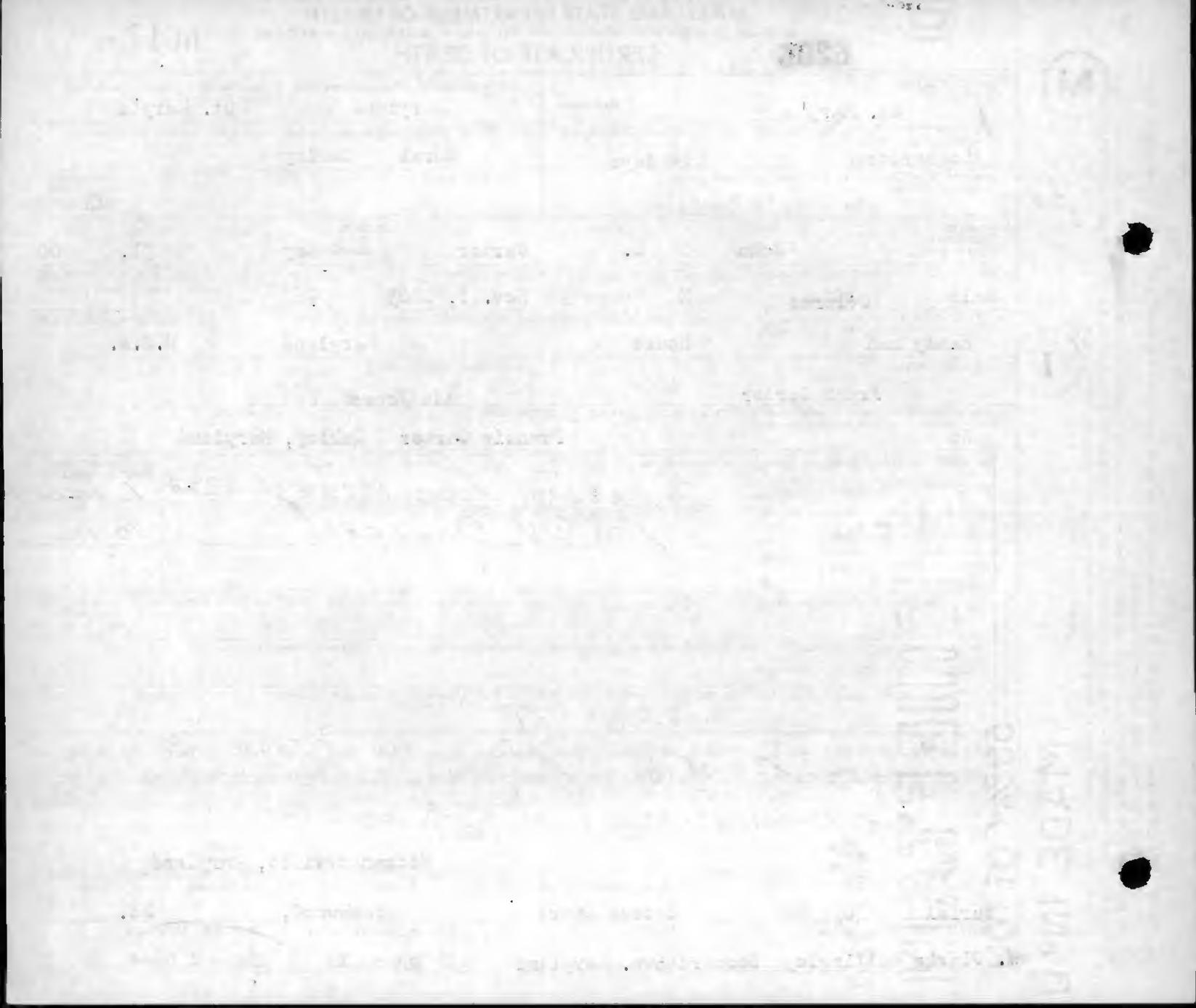
CERTIFICATE OF DEATH

06175

6206

Item 1 Form 6206 6-9-60 et

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH D. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) D. STATE | |
| St. Mary's MARYLAND | | Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | c. LENGTH OF STAY IN lb 24 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Oakley | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) | First John | Middle D. | Last Carter |
| 4. DATE OF DEATH | Month May | Day 31, 1960 | Year |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH |
| Male | Colored | | Nov. 1, 1883 |
| 9. AGE (In years less birthday) 76 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy man | 11. KIND OF BUSINESS OR INDUSTRY House | 12. BIRTHPLACE (State or foreign country) Maryland |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | |
| Frank Carter | Ada Jones? | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
| | | Francis Carter | Oakley, Maryland |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | |
| 422.01 | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) | | | |
| DUE TO | | | |
| ASCV Disease | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 hr | | | |
| DUE TO | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY | Month | Day | Year |
| Hour o. m. p. m. | | | |
| | | 19 | |
| 20d. INJURY OCCURRED | While at work <input type="checkbox"/> | Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | | |
| | (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to May 31, 1960, that (I) (we) last saw the deceased alive on May 31, 1960, and that death occurred at M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> |
| 22c. PHYSICIAN'S NAME (Type) | 22d. ADDRESS | | |
| | Mechanicsville, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORIAL | 23d. LOCATION (City, town, or county) |
| Burial | 6/3/60 | Sacred Heart | Bushwood, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| W. Clarke Mattingly | Leonardtown, Maryland | JUN 3 '60 | Arthur S. Trahan |



FOR STATE
HEALTH DEPT.

Items 18-21 Film 262 MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66176

1. PLACE OF DEATH
a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (If outside corporate limits,
write RURAL and give nearest town)

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Patuxent River near Sotterly Wharf

3. NAME OF
DECEASED
(Type or print)

First Middle

JAMES

RILEY

ELLIOTT

5. SEX

6. COLOR OR RACE

Male

White

WIDOWED

DIVORCED

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Nov. 3, 1927

Last

DEATH

Found

Month

May

2, 1960

Year

Day

Year

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

farmer

10b. KIND OF BUSINESS OR INDUSTRY

waterman

11. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

Perry Elliott

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes or no, or unknown. If yes, give war or date of serv.)

Yes WW II

16. SOCIAL SECURITY NO.

213-22-1483

17. INFORMANT

Maryland State Police

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Drowning

851X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.
(b)
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN
ONSET AND DEATH

19. WAS AUTOPSY
PERFORMED?

YES NO

18 MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell overboard while dredging for oysters

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 2/12 1960

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)
River Sotterly (Patuxent R.) Md

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5/2/60

ACTUAL
SIGNATURE

Russell S. Fisher, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country) (State)

Burial May 4, 1960 Brooms Island Cem Calvert Co

23. FUNERAL DIRECTOR

ADDRESS

24e. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59



Item 18 Film 264 6-3-69 MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE
 HEALTH DEPT



622 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06177

1. PLACE OF DEATH
 a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Oakville

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
 DECEASED
 (Type or print)

First

Middle

Last

Delia

A.

FENWICK

Rural

4. DATE
 OF
 DEATH

Month
 May

Day
 20
 Year
 1960

5. SEX

Female

6. COLOR OR RACE

Colored

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

B. DATE OF BIRTH

11 - 25- 1898

9. AGE (In years
 last birthday)
 61 yrs.

IF UNDER 1 YEAR
 Months Days Hours Min.
 IF UNDER 24 HRS.
 Hours Min.

10a. USUAL OCCUPATION (Give kind of work
 done during most of working life, even if retired)

Housewife

Domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

Henry Butler

Georgiana Forbes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Harry L. Fenwick - RFD Mechanicsville,
 Md.

INTERVAL BETWEEN
 ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a)

Arteriosclerotic cardiovascular disease

DUE TO

422. /
 Conditions, if any, which
 gave rise to immediate cause
 (a), stating the underlying
 cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
 PERFORMED?
 YES NO

20a. EXTERNAL CAUSE WAS
 PRIMARY or CONTRIBUTING
 CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
 Month, Day, Year
 Hour a.m.
 p.m. 19

20d. INJURY OCCURRED
 While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5/20/60

ACTUAL
 SIGNATURE

W. Bradley King, Jr., M.D.

Address (Street, city, town, or county)

EXAMINER'S
 NAME (Type)

22d. LOCATION (City, town, or country)

(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

Burial 5/23/60

St. Joseph

Morganza, Md.

23. FUNERAL DIRECTOR

P.B. Robinson - Leonardtown, Md.

24e. REC'D BY REGISTRAR

MAY 25 '60

24b. REG STRAR'S SIGNATURE

Collis S. Knapp

TO DOCTOR: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
 5M 7/59

[

6 9 A 4 A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

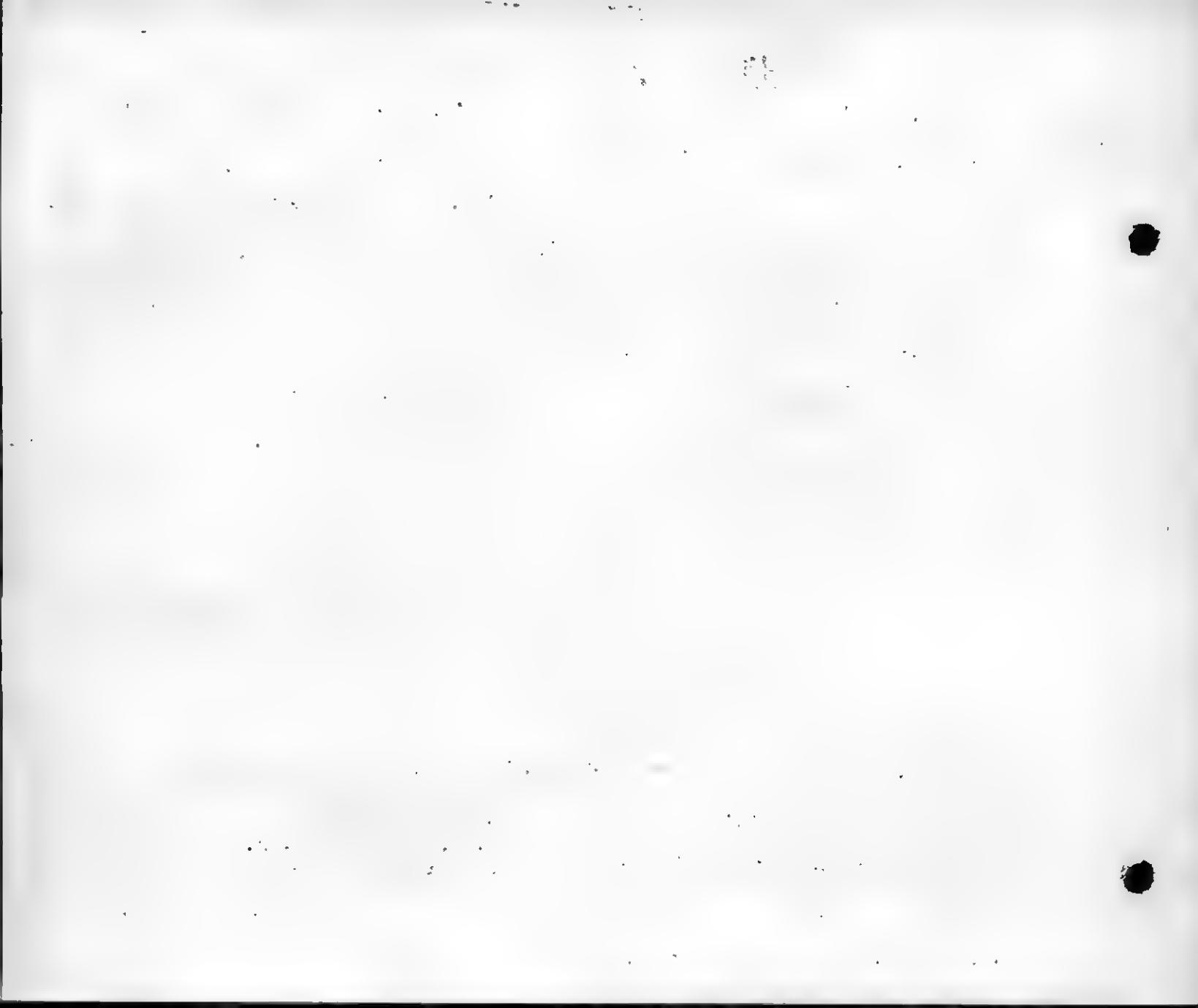
66178

6222

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Lexington Park | | c. LENGTH OF STAY IN 1b D.O.A. 2 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNAS HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park | |
| 3. NAME OF DECEASED (Type or print) Timothy Wayne FLOWERS | | First Timothy | Middle Wayne |
| 4. DATE OF DEATH May 29 1960 | | Month May | Day 29 |
| 5. SEX Male | | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH March 22, 1960 | | 9. AGE (In years lost birthday) yrs. 2 | 10. IF UNDER 1 YEAR Months 2 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME George Ervin FLOWERS | |
| 14. MOTHER'S MAIDEN NAME Honoria Faye ANDREWS | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. None | | INFORMANT Father: George Ervin FLOWERS Address 67 East Rennell Ave., Lexington Park, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation 762. C DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from alive on Dead on arrival , 19 , and that death occurred on 29 May 1960 . | | 19 to 19 that I last saw the deceased from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE <i>J. D. Rudolph, Jr.</i> | | M.D. Station Hospital U. S. Naval Air Station Patuxent River, Maryland | |
| PHYSICIAN'S NAME (Type) S. F. RUDOLPH, LT MC USN | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/1/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Ebenezer | | 22d. LOCATION (City, town, or county) (State) Great Mills, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | 24a. REC'D BY REGISTRAR DATE JUN 3 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i> | |

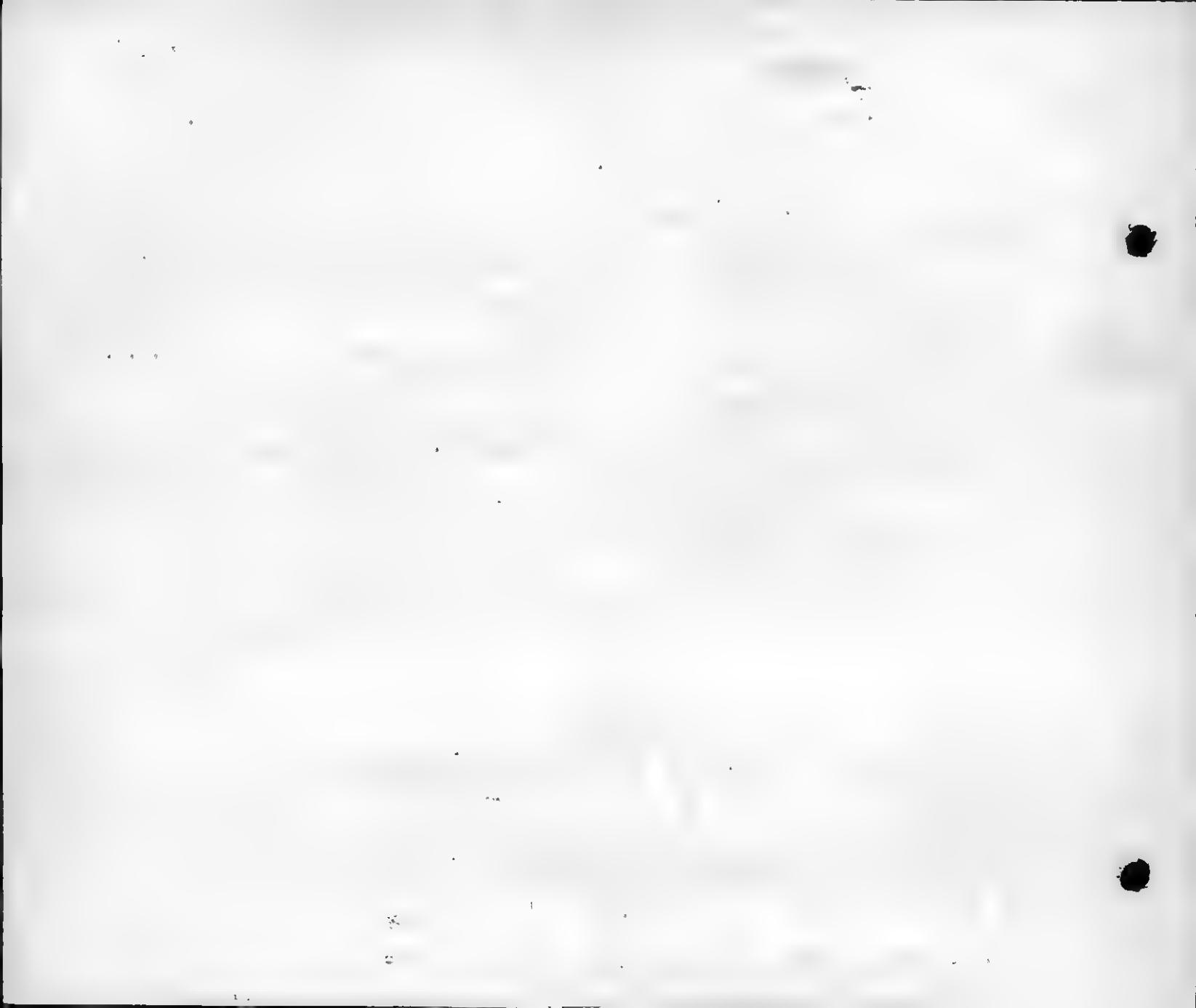


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | CERTIFICATE OF DEATH | | 66179 | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|---|--|---------|--|
| 6207 | | Item is filled out 6-13-60 et | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | St. Mary's | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) | | o STATE | | Maryland | | e IS RESIDENCE ON A FARM? | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Leonardtown | | c. LENGTH OF STAY IN lb | | 12hrs. | | b. COUNTY | | St. Mary's | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | St. Mary's Hospital | | d. STREET ADDRESS | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Lucille | | Middle Greene | | 4. DATE OF DEATH | | Month May | | Day 31 | | Year 1960 | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Female | | Colored | | | | 1913 June ? 1944 | | 46 yrs | | Months | | Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| House wife | | | | Home | | | | Maryland | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Stephen Dyson | | | | Mary Agnes Calvery | | | | Address | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | Florence E. Lawrence Valley Lee, Maryland | | | |
| PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | | | | DUE TO | | | | Myocarditis Infection. | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | | | (b) | | | | | | | | | | | |
| DUE TO | | | | (c) | | | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| Perforated Peptic Ulcer & Decarcelated Umbilical Hernia. | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 19 | | | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 31 May 1960 to 31 May 1960, that (I) (we) last saw the deceased alive on 5 (May) 1960 and that death occurred at P.M. from the causes and on the date stated above | | | | | | | | | | | | | | | |
| 22a. SIGNATURE | | M.D. | | ATTENDING PHYS | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED | | | | | |
| Ernest D. Rehm | | | | | | | | | | 31 May 1960 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | Lexington Park, Md. | | | | | | | | | | | |
| Burial | | 6/4/60 | | St. George's | | 23d. LOCATION (City, town, or county) | | (State) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORIAL | | Valley Lee, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| W. Clarke Mattingley Leonardtown, Maryland | | | | DATE JUN 6 '60 | | Arthur S. Krause | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6223

CERTIFICATE OF DEATH

06180

| | | | | | |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hollywood | | |
| c. LENGTH OF STAY IN 1b Life | | | d. STREET ADDRESS / | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Grace | | | First Elizabeth | Middle Greenwell | Last May |
| 4. DATE OF DEATH 20, 1960 | Month May | Day 20 | Year 1960 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH Dec. 3, 1897 | 9. AGE (In years last birthday) 62 | IF UNDER 1 YEAR Months 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Maryland | IF UNDER 24 HRS Days 0 |
| 13. FATHER'S NAME James Robert Higgs | | | 14. MOTHER'S MAIDEN NAME Margaret Lee Dean | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Mrs Paul Jameson Hollywood, Maryland | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) | | |
| 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1960 to May 20, 1960 , that (I) (we) last saw the deceased alive on May 17, 1960 , and that death occurred at 5 AM , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Charles Greenwell M.D. | | | ATTENDING PHYS. <input type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> |
| 22c. PHYSICIAN'S NAME (Type) Charles Greenwell M. D. | | | 22b. DATE SIGNED | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 5/23/60 | 23c. NAME OF CEMETERY OR CREMATORIAL St. John's | 23d. LOCATION (City, town, or county) (State) Hollywood, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | | ADDRESS | 25a. REC'D BY REGISTRAR MAY 24 '60 | 25b. REGISTRAR'S SIGNATURE Charles S. Kraus |



1
FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in ~~any case~~ within 72 hours after death.

VS. ATSMF
SM 7/59

W. Clarke Mattingley Leonardtown, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06181

1. PLACE OF DEATH

b. COUNTY

St. Mary's

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Leonardtown

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

St. Mary's Hospital

MARYLAND

c. LENGTH OF STAY IN lb

D.O.A.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

St. Mary's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Hollywood

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First Middle Last

Francis Roger

Hayden

DATE
OF
DEATH

May

13, 1960

Year

5. SEX

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

Sept. 9, 1917

9. AGE (in years
last birthday)

42 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Grader Operator

State Road

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Francis Roger Hayden Sr.

Mary Gertrude Wells

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank date of service)

No

216-18-5174 Teresa H. Hayden

Hollywood, Maryland

18. CRUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

823 X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Multiple Crushing injuries

INTERVAL BETWEEN
ONSET AND DEATH

15 min

19. WAS AUTOPSY PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

auto accident. ran off road, hit tel. pole

20c. TIME OF INJURY Month, Day, Year
Hour p.m.
11:55 5/12 1960

20d. INJURY OCCURRED WHILE
At work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

Laurel Drivn st May 1960

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

SIGNATURE *William D. Boyd*

ASSISTANT MEDICAL EXAMINER

M.D. DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

5/13/60

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 5/16/60

22b. DATE THEREOF

St. John's

22c. NAME OF CEMETERY OR CREMATORIUM

Hollywood, Maryland

22d. LOCATION (City, town, or country)

Hollywood, Maryland

(State)

23. FUNERAL DIRECTOR

REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

DATE MAY 16 '60

Arthur S. Krause

$\sigma_{\text{C}_2\text{H}_4}$

~~1~~
FOR STATE
HEALTH DEPT.

~~M~~

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16182

1. PLACE OF DEATH
a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Lexington Pk.

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day Year

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House wife

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

July 23, 1920

9. AGE (In years
last birthday)

39 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS

Days

Hours Min.

13. FATHER'S NAME

John J. Greenwell

14. MOTHER'S MAIDEN NAME

Grace Elizabeth Higgs

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

577-26-6597

Paul Jameson

Hollywood, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

819X

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Broken Neck

INTERVAL BETWEEN
ONSET AND DEATH
immed.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Auto accident - car skidded, hit guard rail & overturned

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 12:05 p.m. 5/28, 1960

20d. INJURY OCCURRED Wh la Not White

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

Road Rt. 235 Lexington Park St. Mary's Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE

William D. Boyd M. D.

ASSISTANT MEDICAL EXAMINER

EXAMINER'S
NAME (Type)
REMOVAL (Specify)
Burial

22b. DATE THEREOF

5/31/60

22c. NAME OF CEMETERY OR CREMATORIUM

St. John's

22d. LOCATION (City, town, or county)

Hollywood, Md.

DATE SIGNED
5/28/60

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

23. FUNERAL DIRECTOR

ADDRESS

W. Clarke Mattingley Leonardtown, Maryland

24e. REC'D BY REGISTRAR

JUN 2 '60

DATE

24f. REGISTRAR'S SIGNATURE

Charles L. Krause

Clouds

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6225

CERTIFICATE OF DEATH

06185

PLACE OF DEATH

O. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Lexington Park

c. LENGTH OF STAY IN lb

1 year

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Station Hospital

NAS., Patuxent River, Md.

2. **USUAL RESIDENCE** (Where deceased lived — If institution: Residence before admission)

O. STATE Maryland

b. COUNTY St. Mary's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Lexington Park

d. STREET ADDRESS

37 Lei Drive

e. IS RESIDENCE
ON A FARM?
YES NO

3. **NAME OF
DECEASED**
(Type or print)

First

Middle

Last

Roxanne

(n)

LAYNE

4. **DATE
OF
DEATH**

Month

May

Day

1 1960

5. **SEX**

6. **COLOR OR RACE**

Female

Cauc.

7. **MARRIED** **NEVER MARRIED**

WIDOWED DIVORCED

8. **DATE OF BIRTH**

4-1-59

9. **AGE (In years
lost birthday)**

1
yrs.

IF UNDER 1 YEAR

Months Days Hours Min

10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

Infant child

10b. **KIND OF BUSINESS OR INDUSTRY**

11. **BIRTHPLACE** (State or foreign country)

Maryland

12. **CITIZEN OF WHAT COUNTRY?**

U.S.A.

13. **FATHER'S NAME**

Elbert Aburey LAYNE

14. **MOTHER'S MAIDEN NAME**

Joan Beverly CULLISON

Address 37 Lei Dr.,
LexPk., Md.

15. **WAS DECEASED EVER IN U. S. ARMED FORCES?**

(Yes, no, or unknown)

No

16. **SOCIAL SECURITY NO.**

—

17. **INFORMANT**

Joan Beverly
Mother LAYNE

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

PNEUMONIA

INTERVAL BETWEEN
ONSET AND DEATH
48 Hours

4 DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.
(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day Year
Hour o. m. p. m. 19

20d. INJURY OCCURRED
While Not while
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from 4-30 1960, to 5-1 1960, that (we) last saw the deceased alive on 1 May 1960 and that death occurred at 12:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE

James H. Armstrong

M.D.

ATTENDING
PHYS

MED.
DIRECTOR

STAFF
PHYS

22b. DATE
SIGNED
5-1-60

22c. PHYSICIAN'S
NAME (Type)

LT. J. H. ARMSTRONG, MC, USN

22d. ADDRESS

Station Hospital

NAS., Patuxent River, Md.

23a. BURIAL CREMATION
REMOVAL (Specify)

5-1-60

23b. DATE THEREOF

5/5/60

23c. NAME OF CEMETERY OR CREMATORI

Holy Face

23d. LOCATION (City, town, or county)

Great Mills, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

W. Clarke Mattingley Leonardtown, Maryland

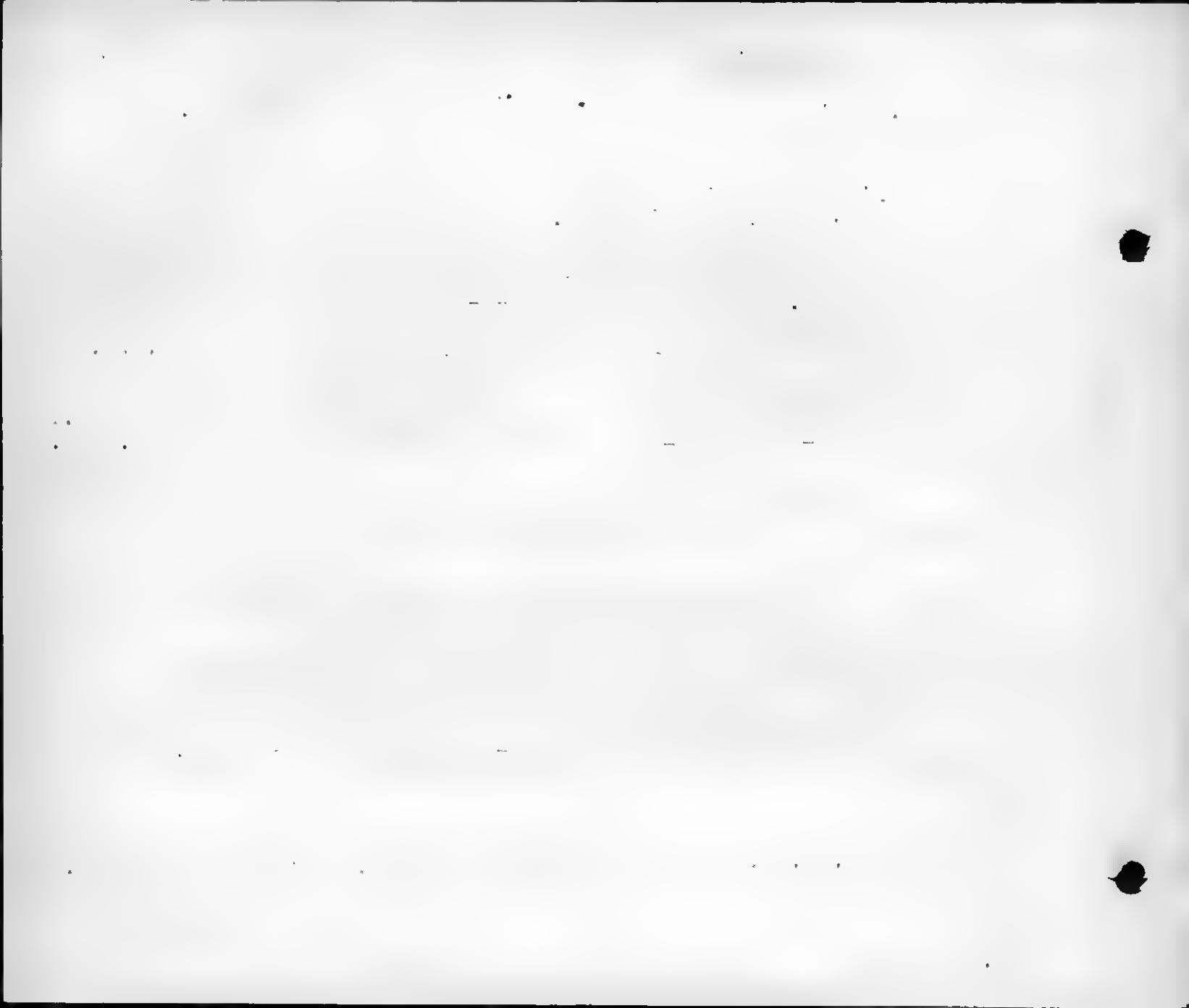
25a. REC'D. BY REGISTRAR

MAY 9 1960

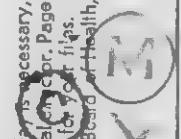
25b. REGISTRAR'S SIGNATURE

Clarke Mattingley

DATE



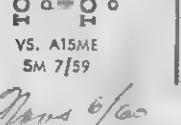
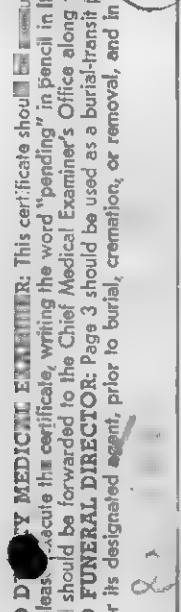
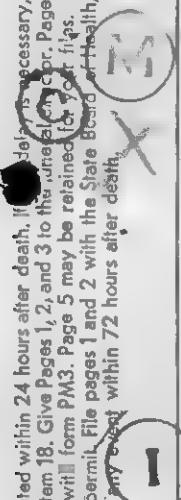
FOR STATE
HEALTH DEPT.



1
TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if necessary, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. It should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

News 6/60



News 6/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

622 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

46183

1. PLACE OF DEATH

a. COUNTY

ST MARY'S

MARYLAND

b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]

LEXINGTON PARK

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address]

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

MARYLAND

b. COUNTY

ST MARY'S

c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]

RURAL, LEXINGTON PARK,

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

BABY BOY LUCAS

First Middle Last

4. DATE
OF
DEATH

Month Day Year

5 10 1960

5. SEX

MALE COLORED

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

5/10/60

10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired]

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

9. AGE (In years
last birthday)

IF UNDER 1 YEAR
Months Days Hours Miles

Yrs.

IF UNDER 24 HRS.

Hours Miles

3

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LEON R.

HARRIS

14. MOTHER'S MAIDEN NAME

MARY ETHEL LUCAS

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give rank or date of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

NONE

MARY ETHEL LUCAS

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

736.0
Conditions, if any which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Suffocation

INTERVAL BETWEEN
ONSET AND DEATH

ceased

MEDICAL CERTIFICATION

20a. TIME OF INJURY

Month, Day, Year

Hour a.m.

20c. INJURY OCCURRED

While

Not While

at work

at work

at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Laytonsville Md

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry

and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

ACTUAL
SIGNATURE

WILLIAM D BOYD MD

Address (Street, city, town, or county)

22e. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

5/14/60

22c. NAME OF CEMETERY OR CREMATORIUM

St. Alloys

22d. LOCATION (City, town, or country)

Leonardtown

(State)

23. FUNERAL DIRECTOR

ADDRESS

McClary Mortuary Leonardtown Md

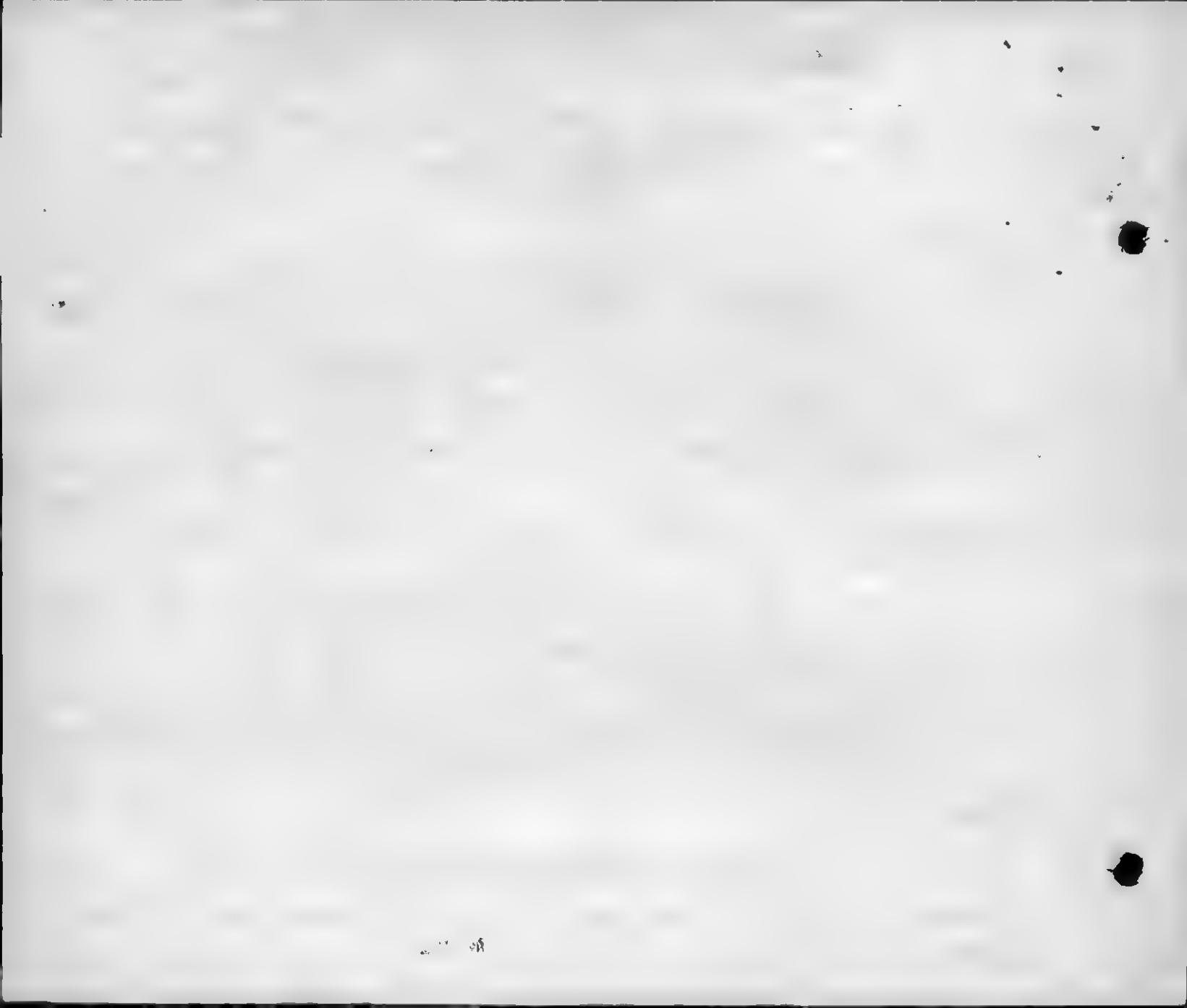
24e. REC'D BY REGISTRAR

JUN 1 '60

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



1
FOR STATE
HEALTH DEPT.

delay is necessary,
please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health
or its designated agent, prior to burial, cremation, or removal, and return page 3 within 72 hours after death.

V.S. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6227 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06184

1. PLACE OF DEATH
a. COUNTY

St. Mary's County

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HOLLYWOOD

c. LENGTH OF STAY IN lb

7 YEARS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

May 13,

19 60

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

JULY 4, 1915

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

9. AGE (In years
last birthday)
44 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN MOORE

14. MOTHER'S MAIDEN NAME

UNKNOWN

Address

HOLLYWOOD, Md.

INTERVAL BETWEEN
ONSET AND DEATH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

CHARLES G. MARSHALL

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Acute Ethanol Intoxication

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.

5:00 P.p.m. 5/12/60

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

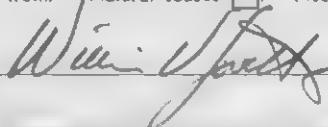
(County)

(State)

home HOLLYWOOD - St. Mary's Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE



CHIEF MEDICAL EXAMINER

EXAMINER'S
NAME (Type)

ASSISTANT MEDICAL EXAMINER

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

5/16/60

22c. NAME OF CEMETERY OR CREMATORIUM

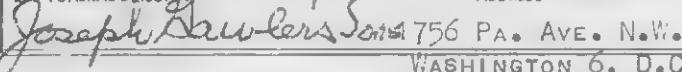
CEDAR HILL CEMETERY

22d. LOCATION (City, town, or country)

(State)

SUITLAND, Md.

23. FUNERAL DIRECTOR

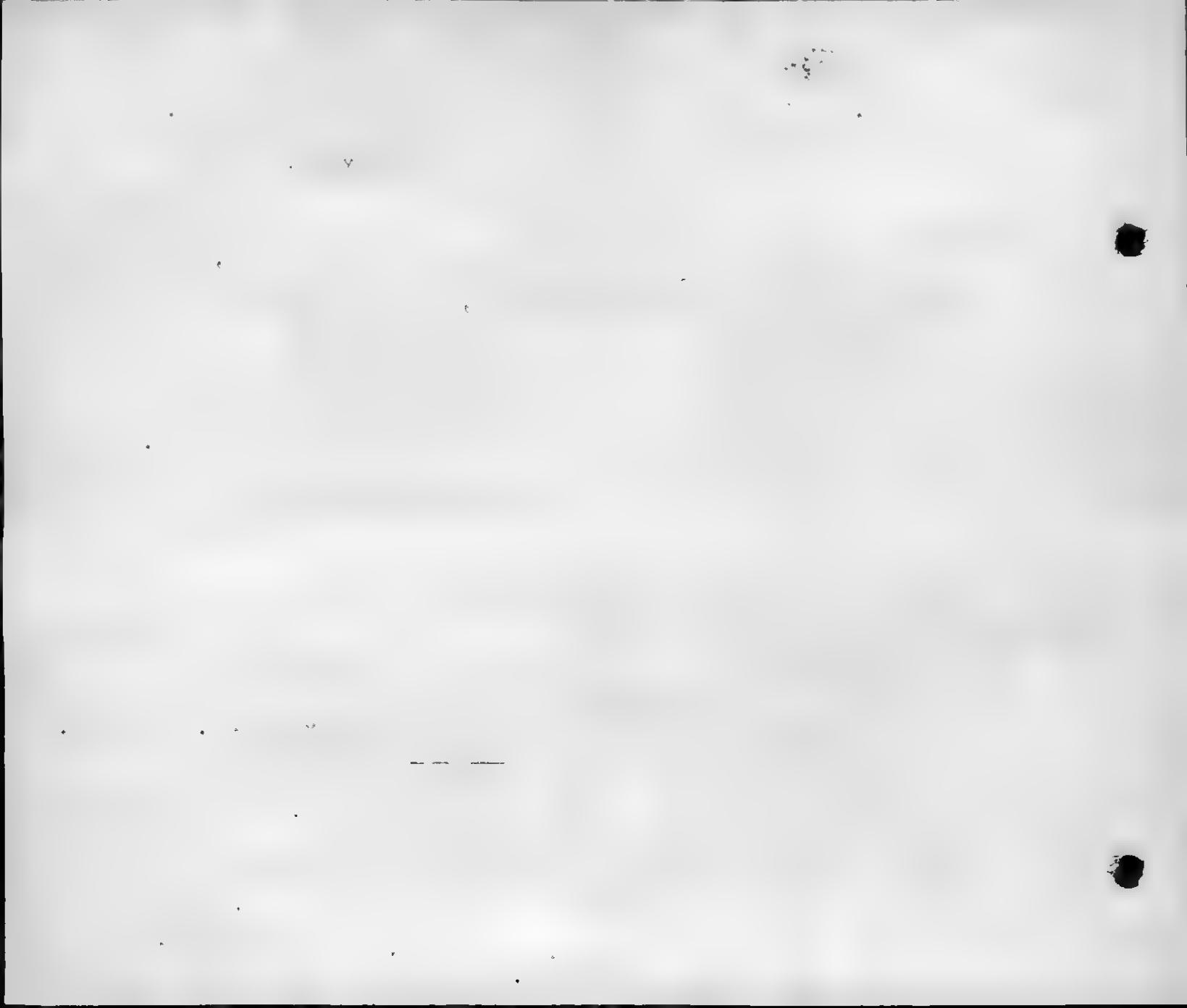

Joseph Hawker's Sons 756 PA. AVE. N.W.
WASHINGTON 6, D.C.

24e. REC'D BY REGISTRAR

DATE MAY 17 '60

24f. REGISTRAR'S SIGNATURE





TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

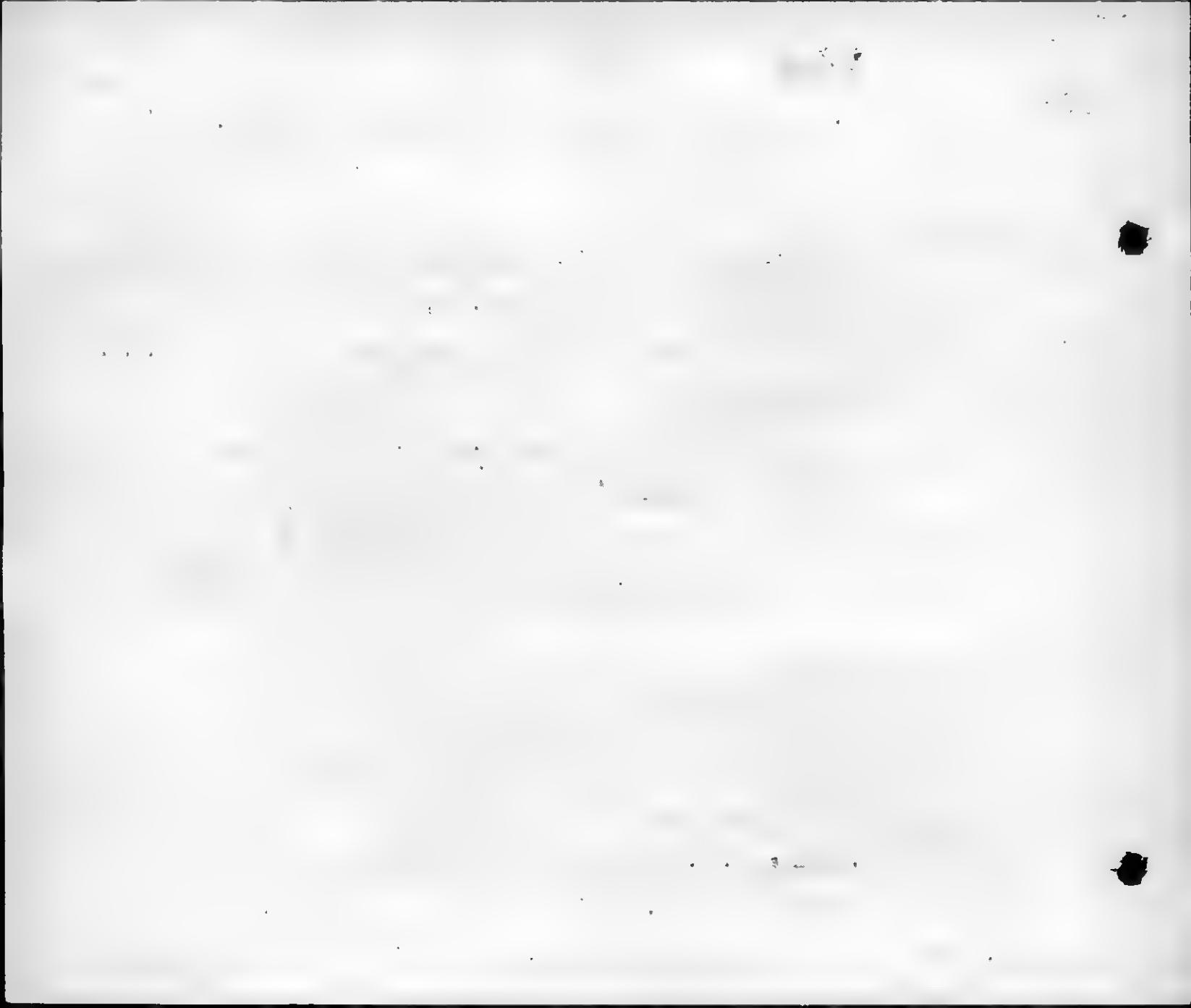
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06186

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE | |
| St. Mary's MARYLAND | | Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood Rural | c. LENGTH OF STAY IN 1b Life | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Hollywood | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS / | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First Mary | Middle Beatrice |
| 4. DATE OF DEATH | | Last Mattingly | Month May |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| Female | | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) Sept. 16, 1901 58 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Andrew Grant Wallace | | 14. MOTHER'S MAIDEN NAME Tose Elizabeth Redman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 17 INFORMANT none Albert L. Mattingly Hollywood, Maryland Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | Born Hepatic Coma Carcinomatosis Carcinoma of the liver INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10.15.59 to 19.60 that (II) (we) last saw the deceased alive on 5.7.60 and that death occurred at M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>A. Samuels</i> | | 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) A. Samuels M. D. | |
| 22d. ADDRESS Leonardtown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5/12/60 | 23c. NAME OF CEMETERY OR CREMATORIAL St. John's |
| 23d. LOCATION (City, town, or county) Hollywood, Maryland | | (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | ADDRESS | 25a. REC'D BY REGISTRAR DATE MAY 16 '60 |
| | | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i> |



FOR STATE
HEALTH DEPT.

66187

Reg. Dist. No.

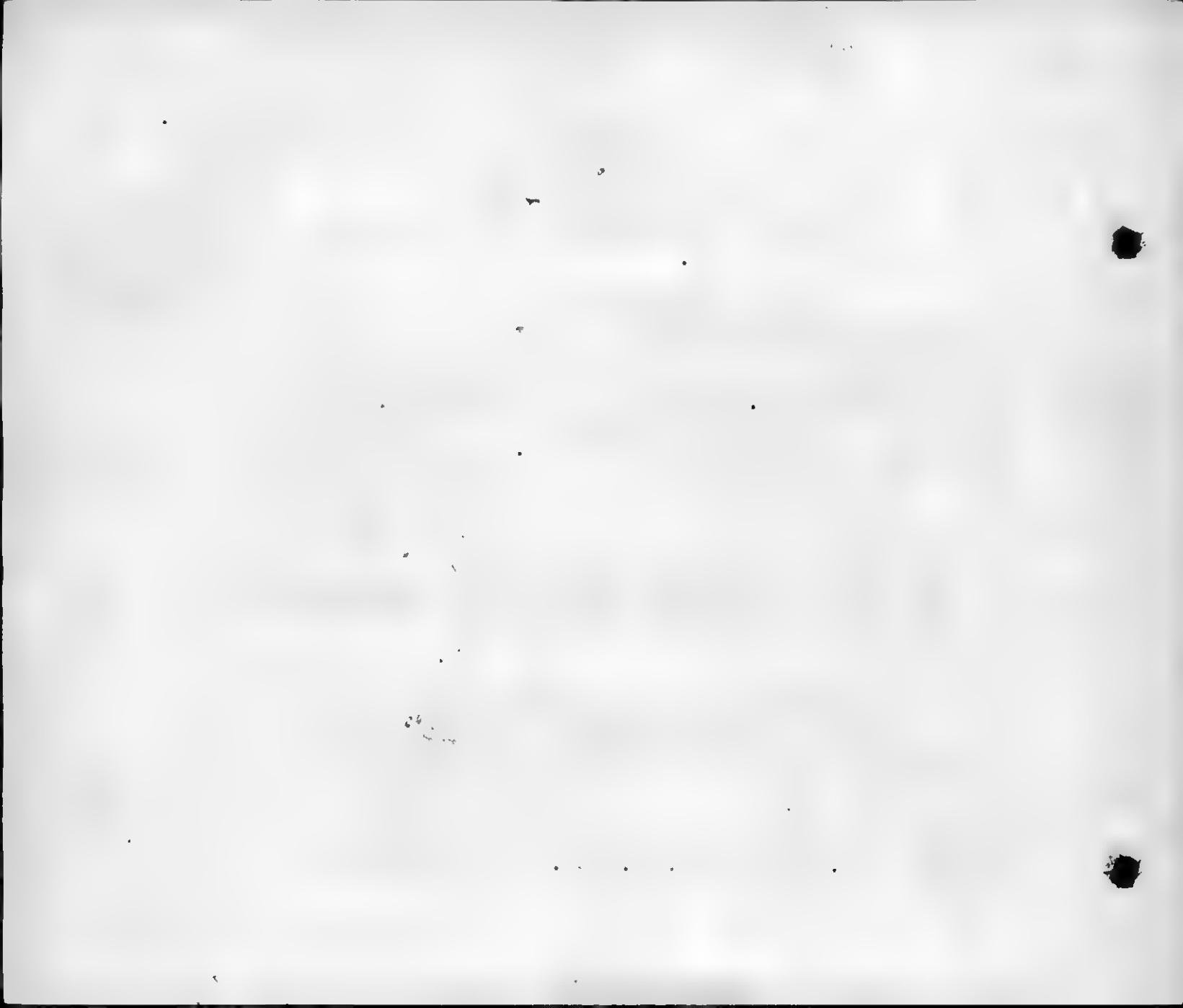
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any
 exec certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the medical director. Page
 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health,
 or its designated agent, prior to burial, cremation, or removal, and in my event within 72 hours after death.

M

X

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| | | | | | | | | |
|---|--|--|---|---|--|---|---------------------------------|--|
| 1 | | 6229 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | |
| PLACE OF DEATH a. COUNTY St. Marys | | MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Leonardtown | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Leonardtown | | c. LENGTH OF STAY IN lb | | | d. STREET ADDRESS / Rural | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Michael | | First A. | Middle Murray | Last | 4. DATE OF DEATH 5/ 16 / 1960 | Month Day Year | | |
| 5. SEX male | | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/ 3/ 1959 | 9. AGE (in years last birthday) — yr. 11 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | | |
| 13. FATHER'S NAME William E. Murray | | 14. MOTHER'S MAIDEN NAME June L. Brady | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Wm. E. Murray - Leonardtown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5/0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUE TO (b) (c) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE W. Bradley King, Jr., M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 5/16/60 | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/19/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery | | 22d. LOCATION (City, town, or county) Baltimore, Md. (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers 8728 Liberty Rd 2046212XV7 | | ADDRESS | | 24a. REG'D BY REGISTRAR DATE MAY 23 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

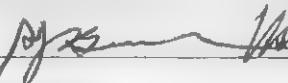
MARYLAND STATE DEPARTMENT OF HEALTH

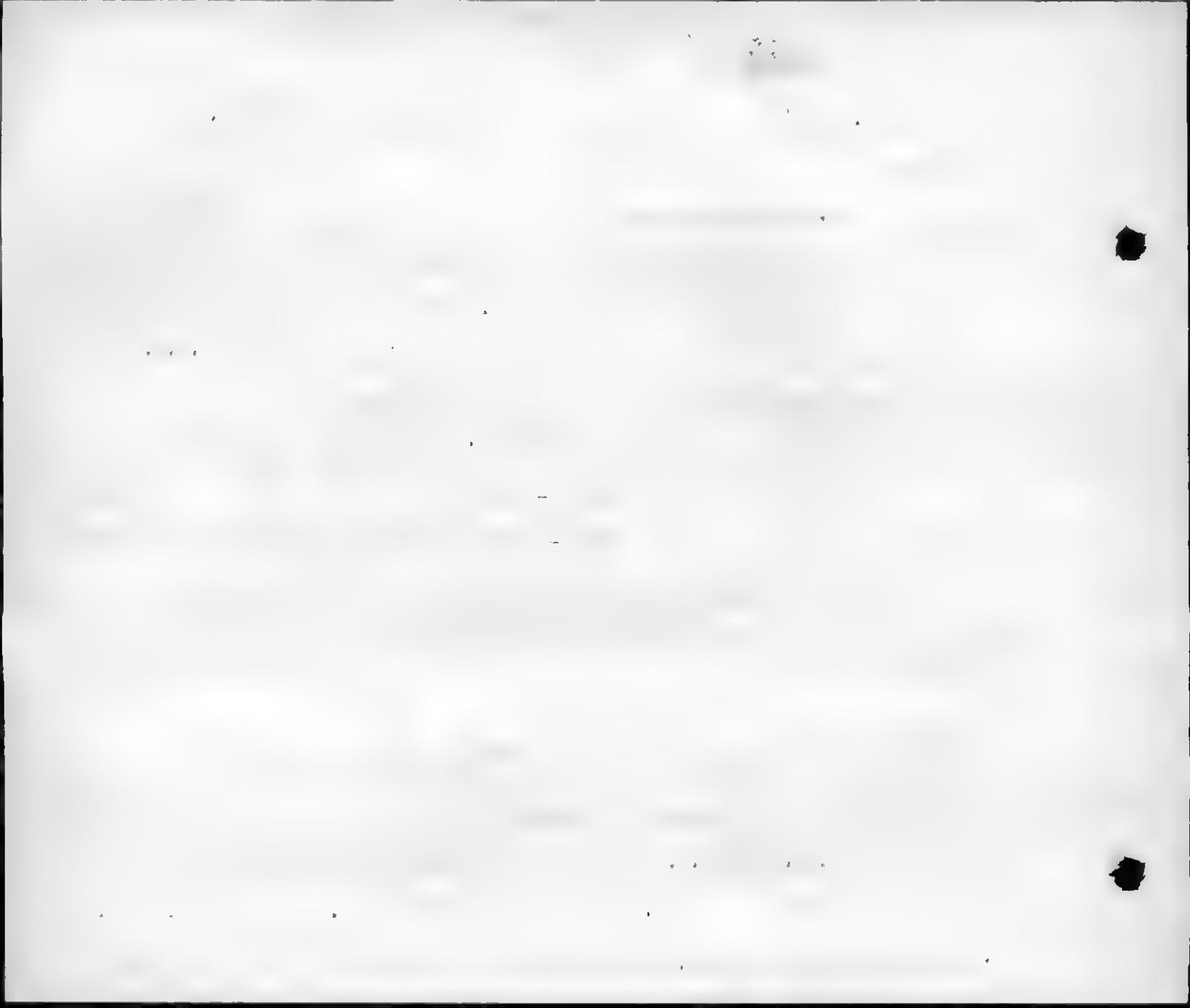
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6209

CERTIFICATE OF DEATH

07311

| | | | | | |
|--|-------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY St. Mary's | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN lb 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Piney Point | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Randall | Middle Scott | Last Nelson | 4. DATE OF DEATH May 10, 1960 | Month Day Year |
| S SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 4, 1956 | 9. AGE (In years last birthday) 3 yrs. | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) Michigan | |
| 13. FATHER'S NAME Joseph Edward Nelson | | 14. MOTHER'S MAIDEN NAME Elizabeth Poe | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Joseph E. Nelson Piney Point, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 57 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | Broncho-Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| | | Fibro-Cystic disease of lungs & pancreas | | birth | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June 1, 1960 to June 10, 1960 that (I) (we) last saw the deceased alive on June 10, 1960 , and that death occurred at 5 P.M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE  | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 6/11/60 | |
| 22c. PHYSICIAN'S NAME (Type) P. J. Bean M.D. | | 22d. ADDRESS Great Mills, Maryland | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 6/13/60 | 23c. NAME OF CEMETERY OR CREMATORIAL St. George Island Methodist | | 23d. LOCATION (City, town, or county) St. George Island, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | ADDRESS | | 25a. REC'D BY REGISTRAR JUN 20 '60 | 25b. REGISTRAR'S SIGNATURE Charles L. Frame |



FOR STATE
HEALTH DEPT.

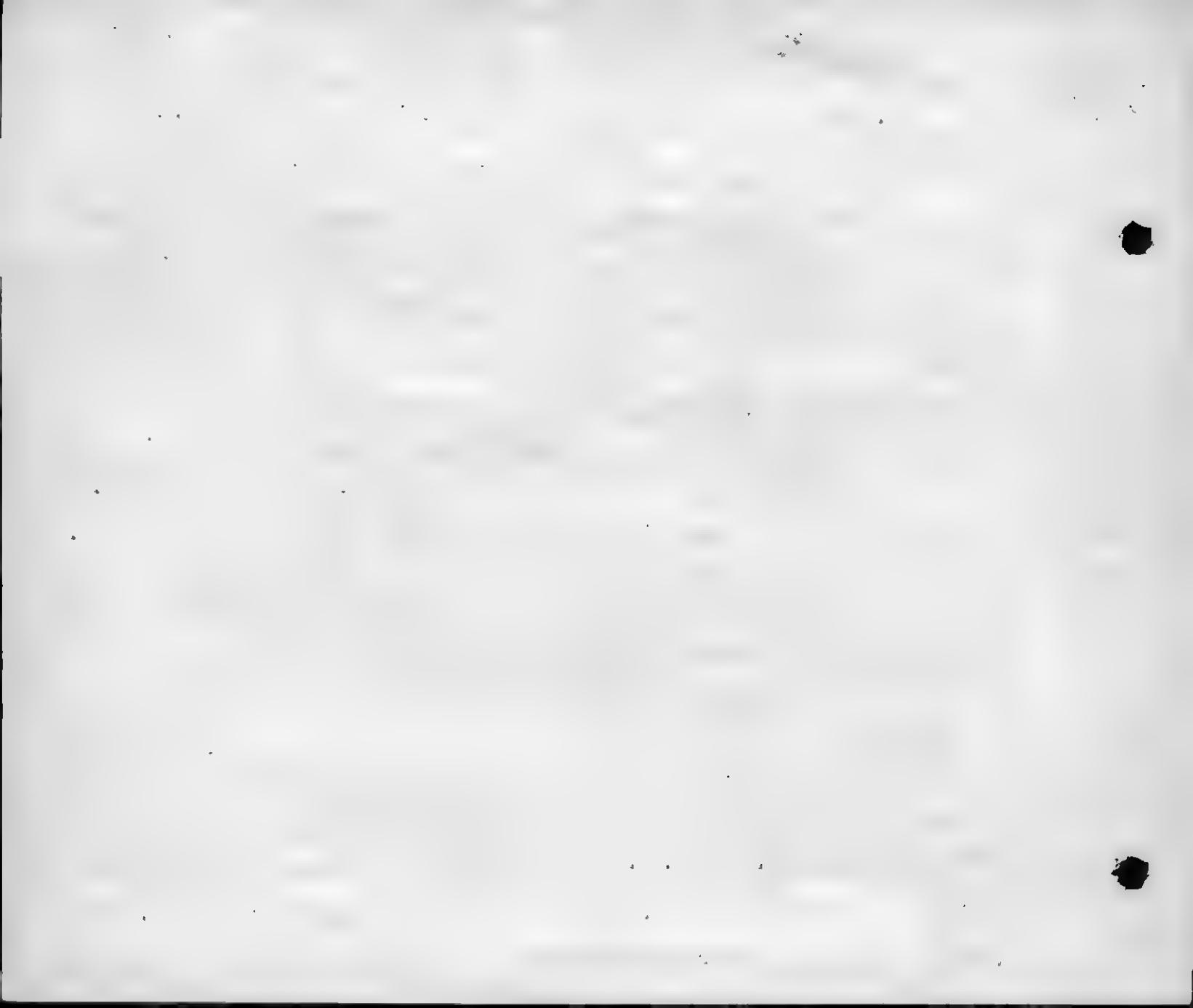
Please enclose the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **06188**

Item 14 Film G-63 3/26/60 1W

| | | | |
|--|--|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | MARYLAND c. LENGTH OF STAY IN lb Rural Mechanicsville Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) Stanley Jerome | First Middle Last Spears | 4. DATE OF DEATH Month Day Year May 9, 1960 | |
| 5. SEX Male | 6. COLOR OR RACE Cloored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH July 5, 1958 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Md | |
| 13. FATHER'S NAME Joseph Spears | 14. MOTHER'S MAIDEN NAME Annie Dorsey | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <input type="checkbox"/> If yes give rank and date of service | 16. SOCIAL SECURITY NO. 123-45-6789 | 17. INFORMANT Joseph Spears Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 75% Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | 19. INTERVAL BETWEEN ONSET AND DEATH Time 2 hrs. | |
| DUE TO (b) acute intestinal obstruction | | Shock | |
| DUE TO (c) Megacolon Colonic Congenital | | Life | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | 19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE William D. Boyd M. D. | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5/12/60 | 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Aloysius | DATE SIGNED 5/10/60 |
| 23. FUNERAL DIRECTOR W. Clarke Mattingley | 24a. REC'D BY REGISTRAR Leonardtown | 24b. REGISTRAR'S SIGNATURE Leonardtown Md. | |
| VS. A15ME 5M 7/59 | DAY | MAY 16 '60 | Orpha S. Thomas |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66189

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>St. Mary's</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lionardtown</i> | c. LENGTH OF STAY IN lb <i>11 days</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Georges, Bunk</i> | d. STREET ADDRESS <i>1</i> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Mary's Hospital</i> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First <i>William</i> | Middle <i>Kerry</i> | Last <i>Spence</i> |
| 4. DATE OF DEATH <i>May 5 1960</i> | Month | Day | Year |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>C</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Jan. 11 1960</i> |
| 9. AGE (in years, months, days) last birthday <i>3 yrs</i> | 10. IF UNDER 1 YEAR Months <i>3</i> | 11. IF UNDER 24 HRS Days <i>Hours</i> | 12. CITIZEN OF WHAT COUNTRY? <i>Md. N.S.G.</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | |
| 10c. BIRTHPLACE (State or foreign country) <i>—</i> | | 11. SOCIAL SECURITY NO. <i>—</i> | |
| 12. FATHER'S NAME <i>William Andrew Spence</i> | | 14. MOTHER'S MAIDEN NAME <i>May Cecilia Clinton</i> Address | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT <i>—</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>092</i> DUE TO <i>Infection Hepatitis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | |
| | | INTERVAL BETWEEN ONSET AND DEATH <i>2-5 wks.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cretin</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>25 April 1960</i> to <i>5 May 1960</i> , and that death occurred at <i>9 M</i> , from the causes and on the date stated above. | | 22b. DATE SIGNED | |
| 22a. SIGNATURE <i>Ernest D. Rehm</i> | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <i>Ernest Rehm M.D.</i> | | 22d. ADDRESS <i>Huntington Park, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>5-6-60</i> | |
| 23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Peter Claver</i> | | 23d. LOCATION (City, town, or county) (State) <i>Ridge Md.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>W.C. Mettingley Leonardtown, Md.</i> | | 25a. REC'D BY REGISTRAR DATE <i>MAY 16 1960</i> | |
| ADDRESS <i>Wood St 2178 151X V51</i> | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

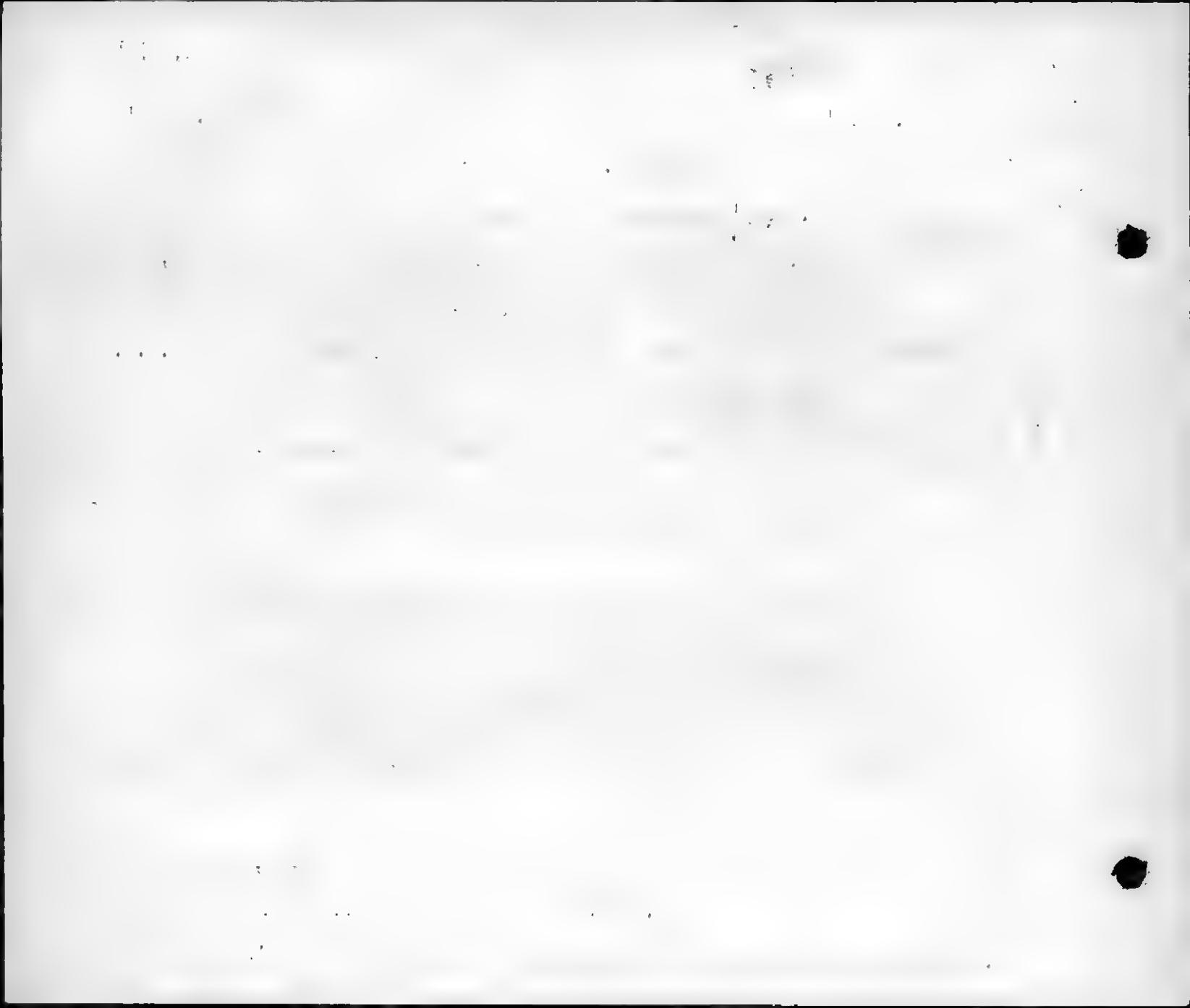
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | | | 06190 | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | | | c. LENGTH OF STAY IN lb 6 days | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X St. George Island | | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | | | | | | | | d. STREET ADDRESS 1 | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) George Marriot | | | | First George Middle Marriot | | | | Last Thomas | | | | 4. DATE OF DEATH May 30, 1960 | | | | | | | |
| 5. SEX Male | | | | 6. COLOR OR RACE White | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH Jan. 28, 1878 | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | 9. AGE (In years last birthday) 82 yrs | | | | | | | |
| 13. FATHER'S NAME W. George Thomas | | | | | | | | 14. MOTHER'S MAIDEN NAME Margaret Henderson | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Lollie S. Thomas | | | | Address St. George Island, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 week | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Embolism | | | | | | | | | | | | | | | | | | | |
| Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General arteriosclerosis | | | | | | | | | | | | 10 years | | | | | | | |
| DUE TO (c) | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aug 10, 1957 to May 30, 1960. | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 10, 1957 to May 30, 1960. that (I) (we) last saw the deceased alive on May 29, 1960. and that death occurred at 7A M. from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE P. J. Bean M. D. | | | | M. D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS Great Mills, Maryland | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 6/1/60 | | | | 23c. NAME OF CEMETERY OR CREMATORIUM St. George Episcopal Cemetery Valley Lee, Maryland | | | | 23d. LOCATION (City, town, or county) (State) Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE JUN 2 '60 | | | | 25b. REGISTRAR'S SIGNATURE Collier S. House | | | |



TO HOSPITAL OR ATTENDANT PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | | | 06191 | |
|--|--|--|--|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 6212 Item 7 Filing 605 3-22-60 et | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN 1b 20 hrs. | | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) J. Frank Thomas | | First | | Middle | | Last | | 4. DATE OF DEATH May 22, 1960 | | Month Day Year | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH May 29, 1875 | | 9. AGE (in years last birthday) 84 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William Henry Thomas | | 14. MOTHER'S MAIDEN NAME Mary Ellen Quade | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Mary Ellen Thomas Maddox, Maryland | | Address | | | | | | | |
| 18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | CONGESTIVE HEART FAILURE INTERVAL BETWEEN ONSET AND DEATH 5 yrs. | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m p. m 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1935 to May 29, 1960 , that (I) (we) last saw the deceased alive on 27 May 1960 and that death occurred at 6 AM , from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE Tom Burke | | M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS Mechanicsville, Maryland | | | | | | | | | | | |
| 23a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5/24/60 | | 23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's Sacred Heart | | 23d. LOCATION (City, town, or county) Morganza, | | (State) Maryland | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley | | ADDRESS Leonardtown, Maryland | | 25a. REC'D BY REGISTRAR DATE MAY 26 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

66192

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN 1b 16 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Richard | Middle | Last White |
| 4. DATE OF DEATH Month May | Month 24, | Day 1960 | Year |
| S. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 15, 1887 |
| 9. AGE (In years last birthday) 73 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water man | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William W. White | 14. MOTHER'S MAIDEN NAME Lucy Medley | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO 218-38-7620 | 17. INFORMANT Alice White | Address Scotland, Maryland |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO ca prostatice (adenocarcinoma) (c) DUE TO metastasis to bone INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that death occurred at _____ M, from the causes and on the date stated above | | | |
| 22a. SIGNATURE Deborah | | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | 22b. DATE SIGNED |
| 22c. PHYSICIAN'S NAME (Type) William H. Patrick M. D. | | 22d. ADDRESS Lexington Park, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/27/60 | 23c. NAME OF CEMETERY OR CREMATORIAL St. Luke's | 23d. LOCATION (City, town, or county) (State) Scotland, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | ADDRESS | 25a. REC'D BY REGISTRAR JUN 1 '60 | 25b. REGISTRAR'S SIGNATURE Charles S. Kraus |



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MARYLAND STATE DEPARTMENT OF HEALTH

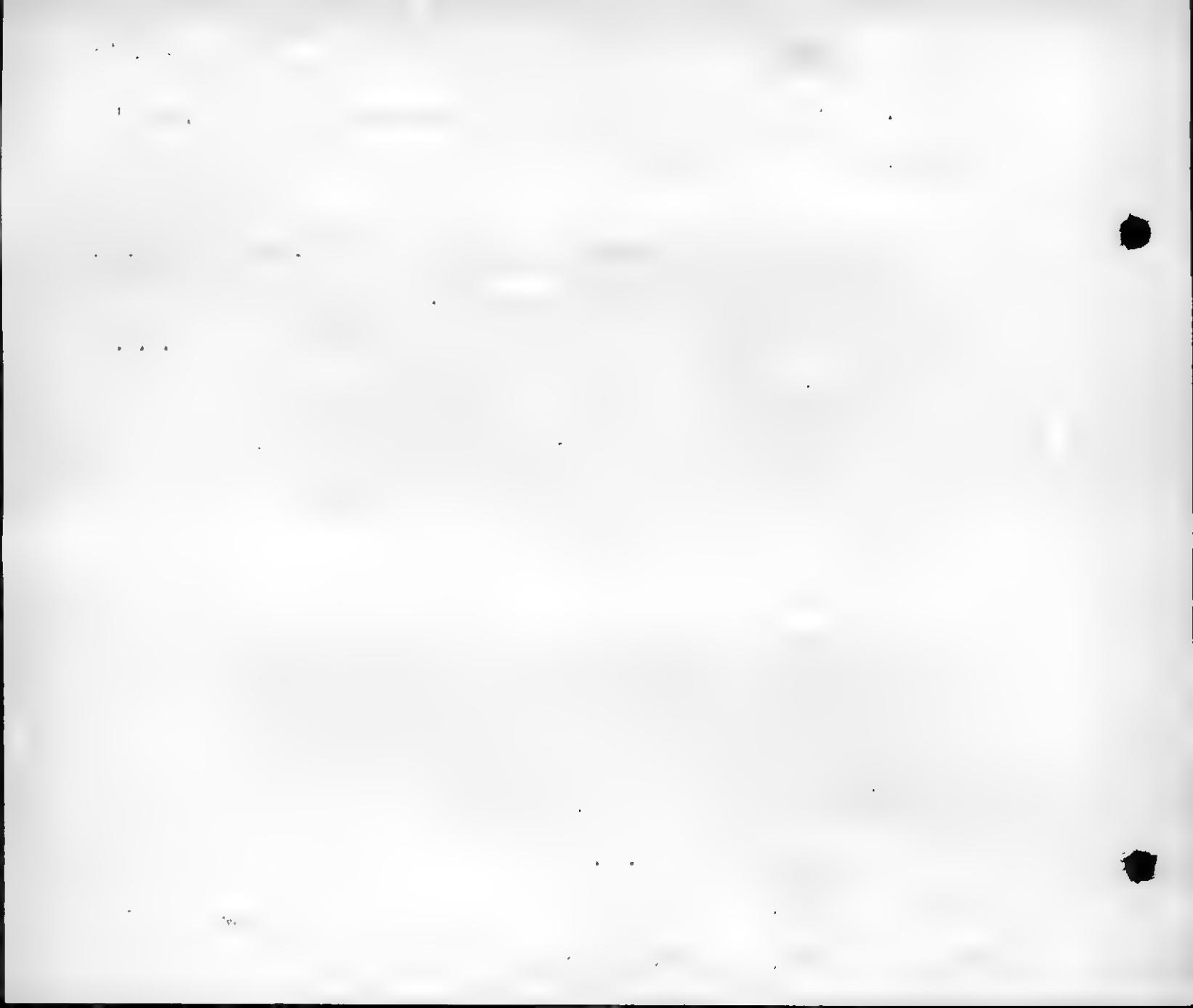
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6231

CERTIFICATE OF DEATH

06193

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Avenue | | c. LENGTH OF STAY IN 1b Life | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY S. t. Mary's | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION | | | | | | d. STREET ADDRESS X Rural Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) James Marshall Wise | | First James | | Middle Marshall | | Last Wise | | 4. DATE OF DEATH 1882 May 8, 1960 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH April 13, 1882 | | 9. AGE (In years last birthday) 78 yrs | |
| | | | | | | | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water man | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Dominic Wise | | 14. MOTHER'S MAIDEN NAME Helena Yates | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO | | 17. INFORMANT | | Address Ann Victoria Wise Avenue, Maryland | | | |
| | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | <i>Cancer of Liver</i> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | | | | | (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/16/59 to 5/8/60 , that (I) (we) last saw the deceased alive on 5/4/60 , and that death occurred at M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <i>Charles Greenwell</i> | | M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED <i>Leonardtown MD</i> | | | |
| 22c. PHYSICIAN'S NAME (Type) Charles Greenwell M. D. | | 22d. ADDRESS <i>Leonardtown MD</i> | | | | | | | |
| 23a. BURIAL, CREMAT. ON, REMOVALS (Specify) Burial | | 23b. DATE THEREOF 5/10/60 | | 23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart | | 23d. LOCATION (City, town, or county) Bushwood, Maryland | | | |
| | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE MAY 10 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |



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VR A15 (4)
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

6213

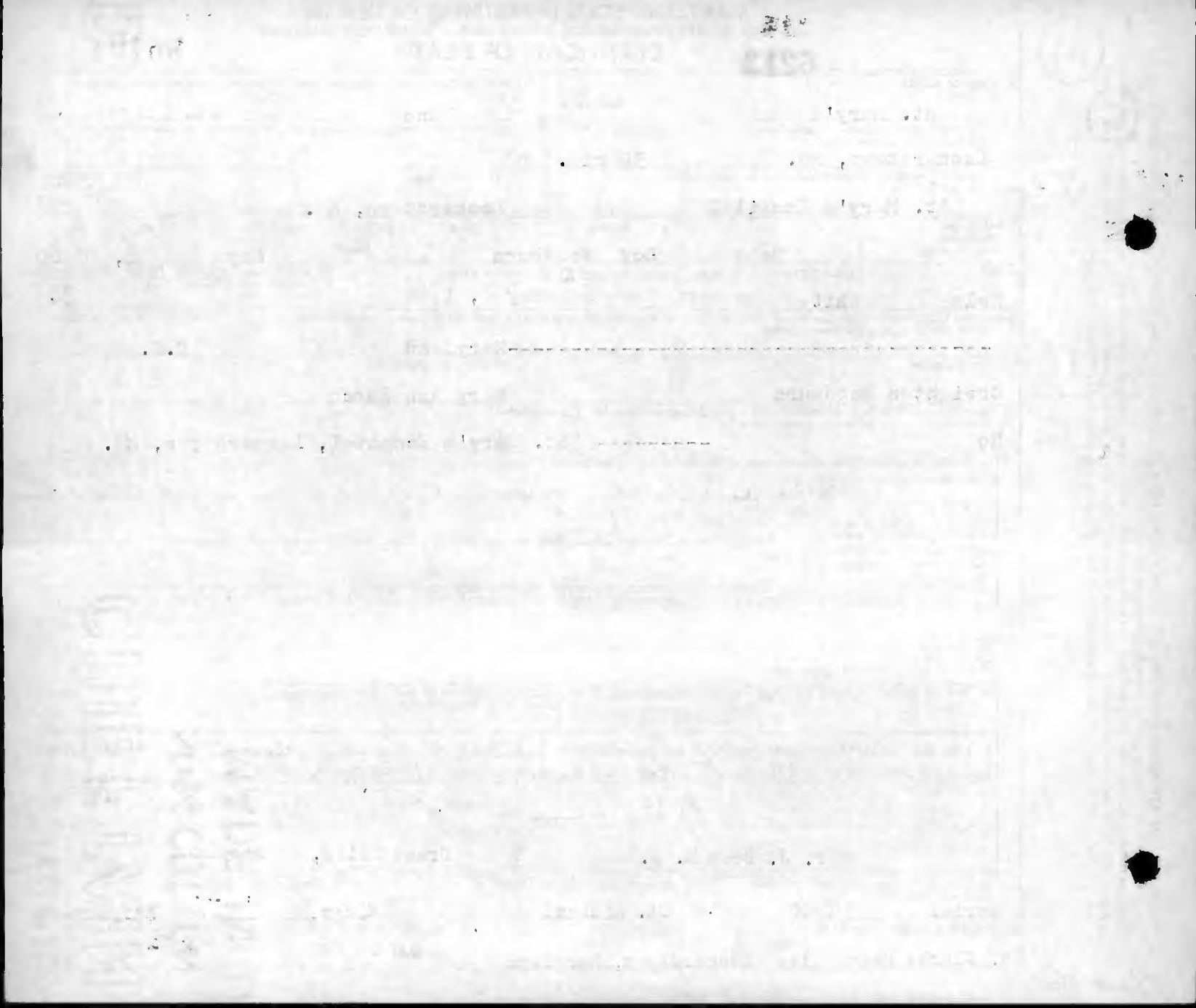
CERTIFICATE OF DEATH

06194

| | | | | | | | |
|---|----------------------------------|--|--|---|---------------------------------------|--|-------------------|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE None | | b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown, Md. | | c. LENGTH OF STAY IN 1b 30 min. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | | d. STREET ADDRESS Leonardtown, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Baby | | First Boy | Middle Woodburn | 4. DATE OF DEATH May | Month 8 | Day 19 | Year 60 |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH May 8, 1960 | 9. AGE (In years lost birthday) yrs. 0 | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Creighton Woodburn | | 14. MOTHER'S MAIDEN NAME Mary Ann Burch | | Address | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 752 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Central Hemorrhage (b) Hydrocephalus (c) | |
| | | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 8, 1960 , to May 8, 1960 , that (I) (we) last saw the deceased alive on May 8, 1960 , and that death occurred at 2957 from the causes and on the date stated above. | | 22a. SIGNATURE P. J. Bean M. D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 20/5/60 | |
| 22c. PHYSICIAN'S NAME (Type) P. J. Bean M. D. | | 22d. ADDRESS Great Mills, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5/8/60 | | 23c. NAME OF CEMETERY OR CREMATORIAL St. Michael | | 23d. LOCATION (City, town, or county) (State) Ridge, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE MAY 20 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

Non 6/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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| | | | | | | | | | |
|--|----------------------------------|---|--|---|--|---|---|-----------------------------|----------------------------|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN lb D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Park Hall | | d. STREET ADDRESS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Albert L. Woodburn | | First Albert | Middle L. | Lost Woodburn | 4. DATE OF DEATH May 3, 1960 | Month May | Day 3 | Year 1960 | |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH Oct. 19, 1895 | 9. AGE (In years lost birthday) 64 yrs. | IF UNDER 1 YEAR Months 0 | | IF UNDER 24 HRS. Days 0 Hours 0 Min. 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Daniel Woodburn | | 14. MOTHER'S MAIDEN NAME Amy L. Guy | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218 24 0567 | | 17. INFORMANT Bertha S. Woodburn | | Address Park Hall, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion | | | | | | INTERVAL BETWEEN ONSET AND DEATH 20 minutes | | | |
| 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Generalized arteriosclerosis | | DUE TO (b) DUE TO (c) | | | | 2 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Great Mills | | (County) Maryland | (State) Maryland |
| 21. I certify that (I) (this hospital) attended the deceased from May 3, 1960 to May 3, 1960 , that (I) (we) last saw the deceased alive on May 3, 1960 , and that death occurred at Great Mills from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE P. J. Bean M. D. | | MD. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS Great Mills, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5/7/60 | | 23c. NAME OF CEMETERY OR CREMATORIAL St. Aloysius | | 23d. LOCATION (City, town, or county) Leonardtown, Maryland | | (State) Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | ADDRESS | | 25a. REC'D BY REGISTRAR Arthur S. Kraus | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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